



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DAVID V. DENT, DO

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-10-3883-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

MAY 4, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On August 25, 2009, a letter was received from Texas Mutual stating that Utilization Review had determined the preauthorized services and/or treatment were medically necessary. The FCE was to be done between 08/25/09 – 09/25/09 and not to exceed 2 hours. Please review this for Dr. Dent and reconsider payment for this claim."

Amount in Dispute: \$1,504.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The request is not complete and should be dismissed... The provider's request for payment should be denied for three reasons. First, Texas Mutual properly denied payment because the provider is in continuing noncompliance with the Division's financial disclosure rule...Second, the provider submitted documentation indicating that the service (FCE) was preauthorized...The 16 units (4 hours) billed clearly exceed the scope of this preauthorization. Third, the bill for 16 units (4 hours) clearly exceeds the time it took to perform this FCE...And, in fact, the documentation submitted by the provider himself does not support a 4 hour FCE. Finally, the FCE itself was not a complete FCE as required by Division Rule 134.204...not all components were done."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2009	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$1,504.32	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §180.24 effective March 14, 2002, sets out the financial disclosure requirements and penalties for healthcare providers.
3. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Per Rule 180.24, Financial Disclosure not met. Number of units billed exceeds number of units performed. Provider is not in compliance with the MFG. See MFDR decision M4-07-6401-01.
 - CAC-B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service.
 - CAC-W1-Workers compensation state fee schedule adjustment.
 - 891-The insurance company is reducing or denying payment after reconsideration.
 - 892-Denied in accordance with DWC rules and/or medical fee guideline.
 - 896-Statutory/regulatory violation.

Issues

1. Does a financial disclosure issue exist?
2. Does the submitted documentation support billing FCE per 28 Texas Administrative Code §134.204? Is the requestor entitled to reimbursement for the FCE rendered on September 18, 2009?

Findings

1. The respondent denied reimbursement for the disputed FCE based upon "Per Rule 180.24, Financial Disclosure not met."

28 Texas Administrative Code §180.24(b) states " Submission of Financial Disclosure Information to the division. (1) If a health care practitioner refers an injured employee to another health care provider in which the health care practitioner, or the health care provider that employs the health care practitioner, has a financial interest, the health care practitioner shall file a disclosure with the division within 30 days of the date the first referral is made unless the disclosure was previously made. This annual disclosure shall be filed for each health care provider to whom an injured employee is referred and shall include the information in paragraph (2) of this subsection."

According to the submitted medical records, the testing was performed at Advocate Pain Management Center in Bellaire, Texas.

The respondent states in the position summary that "Dr. Dent's financial disclosure is attached as Exhibit A. His disclosure to the Division of Workers' Compensation states he is the Medical Director of Pain Management at Memorial MRI and Diagnostic Center and he received no percentages. However, Dr. Dent has undisclosed financial interests in Advocate Pain Management (Bellaire, Texas), Advocate Pain Management Center (Austin, Texas), J. holdings, Inc., Rice Surgery Center, PA, and Southwestern Surgical, PA. See Exhibits B, C, D, E, and F, respectively. Therefore, Dr. Dent has failed to disclose and has violated Division rules."

The Division finds that the respondent submitted Executive Affiliation Records as reported by the Secretary of State or other Official Source to support the position summary. The requestor did not submit documentation to refute the respondent's position summary; therefore, the Division finds a financial disclosure issue exists in this dispute.

2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

On the disputed date of service, the requestor billed CPT code 97750-FC.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:

- (A) appearance (observational and palpation);
- (B) flexibility of the extremity joint or spinal region (usually observational);
- (C) posture and deformities;
- (D) vascular integrity;
- (E) neurological tests to detect sensory deficit;
- (F) myotomal strength to detect gross motor deficit; and
- (G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:

- (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
- (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:

- (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
- (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
- (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
- (D) static positional tolerance (observational determination of tolerance for sitting or standing)."

The requestor submitted a copy of a preauthorization report that indicates "Per mutual agreement with Noami at Dr. Dent's office, preauthorization given for an FCE not to exceed 2 hours to be done between 8-25-09 and 9-25-09 at Advocate Pain Management Center and to be performed and billed in accordance with DWC RULE §134.202(e)(4)."

A review of the submitted explanation of benefits indicates that the requestor billed for sixteen units, which equals four hours; this number exceeds the two hour limit reached via mutual agreement with Noami at Dr. Dent's office and the insurance carrier.

Furthermore, the respondent states "Portions of the FCE were lifted from an earlier office visit that occurred on September 1, 2009. See Exhibit G. For instance, note that the neurological findings are identical in the September 1, 2009 encounter note and the September 18, 2009 FCE." The Division compared the FCE and Office visit report and found that the Neurological findings were identical.

In addition, 28 Texas Administrative Code §134.204(g)(3)(C) requires cardiovascular testing to be performed by using stationary bicycle or treadmill. The requestor noted that the cardiovascular testing was performed using the Kasch Step Test. A review of the submitted documentation finds that the cardiovascular testing

was not performed in accordance with 28 Texas Administrative Code §134.204(g)(3)(C). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	<u>06/10/2015</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.